BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An open forum for brief discussions of the workaday problems of the bedside doctor. Suggestions for subjects for discussion invited.

THE LUMP IN THE BREAST

ALSON KILGORE, SAN FRANCISCO.—In our courts the accused is innocent until proved guilty, but in the breast a lump is cancer until proved benign. The surgeon who advises watchful waiting in the presence of a single definite breast lump in a woman over twenty-five will find too often that he has been watching an early cancer become incurable. Every such lump should be explored. In the examination of a breast (without skin retraction or other classical signs of cancer) decision should be limited to the question of whether an actual lump is present or whether the mass felt by the patient is only a "lumpy" area of breast tissue—a decision that, in itself, often requires no mean skill and experience. And the surgeon should never lose sight of the fact that extended or vigorous examination may cause rapid metastasis of an early cancer. One or two gentle touches must furnish all the information needed. Leaving a breast sore from clinical examination is absolutely inexcusable.

It is today settled and no longer debatable that exploration of a breast lump is justifiable, but it is equally undebatable that if cancer is found, the complete operation must be done at the same time. Frozen section diagnosis should always be available. Occasionally only a microscopic section will settle the diagnosis. But the average hurried frozen section is less trustworthy than paraffin or celloidin sections, and the competent surgeon will depend upon a reasonably clear gross diagnosis rather than on frozen section if the two disagree. The really competent breast surgeon must be at least a good amateur pathologist. It is not too much to ask that he be confident of his recognition of certain typical pictures—of normal breast tissue, of cancer, of the encapsulated lump, of the simple and the papillomatous cyst, and of the nonencapsulated cystadenoma.

But our responsibility is not ended when we have learned to deal properly with breast lumps. We cannot treat early cancers unless our patients bring them early. It has been proved possible to educate communities about breast lumps. There is still room for improvement in popular knowledge in California. Physicians must educate their patients to bring breast lumps for examination the moment of discovery. As a matter of fact, we can well go farther than that. Over 90 per cent of breast cancers are discovered accidentally—unintentional contact of the hand on the breast in bathing or dressing. The accidentally discovered lump has often been present and discoverable for months before it is found. Lumps should be sought for by every woman routinely, not discovered accidentally. If we teach our patients to keep track of themselves as a matter of habit, passing a soaped hand flat over the breasts at frequent intervals, we will see many more curable cancers. And the sensible woman, taught that a lump is the one important danger sign, will not develop a morbid phobia so long as she continues to find her breasts free of lumps.

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EDWIN I. BARTLETT, SAN FRANCISCO.—The old adage, "When in doubt do a complete breast operation," still holds today. At one time it meant the removal of a lot of innocent breasts because we depended entirely upon the clinical diagnosis. Today there need never be any doubt and, therefore, no innocent breasts need be sacrificed. This comes about through the perfection of the exploratory operation and the diagnosis at the operating table by the gross appearance of the tumor or by the frozen section. All cases can be positively diagnosed and properly treated while the patient is still under the primary anesthetic.

The old saying, "Amputation of the breast is not enough for cancer, and too much for anything else," still holds today. Simple amputation is seldom indicated, therefore a woman may have practically a guaranty that she will not lose her breast unless cancer is found. She can be further assured that the gland will be restored completely or nearly to its normal shape, that the function will not be seriously interfered with, that she need have no fears regarding serious discomfort or distress with lactation, and that the skin over the breast will show only a fine white line. To accomplish all this the surgeon makes an incision radiating from the nipple, he dissects the tumor very carefully away from the surface of the gland or simply strips the lining of a cyst. If it becomes necessary to remove a portion of a gland, he takes a wedge-shaped piece with the base of the wedge at the periphery of the breast, and the blade of the wedge toward the nipple. He closes the defect by accurately approximating the posterior cut edges of the gland. He thus avoids lactation trouble by leaving behind no secreting breast tissue which does not have free drainage to the nipple, and he leaves no furrows or depressions in the surface of the breast gland.

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M. T. BURROWS, PASADENA.—While most cancers of the breast make themselves known by the development of a lump, there are a few which fail to give this signal. The cancers which are most frequently missed are those arising from the ducts deep in the breast and the more diffuse cancers which have an acute onset. The first of the latter types are easily diagnosed by the appearance of an eczematous rash about the nipple. A suddenly developing acutely swollen, red and tense breast, especially coming on without warn-

ing, should be considered cancerous until proved otherwise.

While the easiest method of treatment of any breast tumor is exploration and removal it must be remembered that the removal of the breast of a young woman, or even cutting into it, means either robbing this woman of one of the charms of her womanhood or doing injury to the ducts which will be a constant source of trouble to her throughout her sexual life.

Where it is possible to make a definite diagnosis of cancer the breast must be removed. Whether one should advise the immediate removal of every tumor of the breast is a question to be solved. While a few breast cancers make themselves known by the appearance of a rash about the nipple, most cancers of the breast begin in a mastitis of shorter or longer duration or other tumors. Since our recent work on the relation of cancer to vitamin deficiency, we have assumed quite a different attitude toward many of these precancerous lesions. The breast of one woman with an eczematous rash just appearing about the nipple healed completely with the removal of several abscessed teeth and the use of a healthful diet. Cancers were found at operation deep in the breast of two other patients. In one the eczema had existed for six months; in the other, two years.

One sees a tumor often in the breasts of young and middle-aged women who may or may not have borne children. Many of these cases have been associated with a cervicitis, abscessed teeth, and secondary anemias. The breasts of these patients which showed no definite signs of malignancy have not been touched. The associated lesions, on the other hand, have been treated at once. The abscessed teeth have been removed, cervicitis treated, and an attempt has been made to clear the anemia. It is surprising how many breast lesions have disappeared under this treatment. Our method is to institute the treatment of these associated lesions at once. If the breast lesion does not recede or disappear within two to four weeks, operation is then advised. Of the twenty-one cases of this type seen during the last one and a half years, seven have been operated upon and six found malignant.

Besides these types of lesion one sees tumors in the breasts of many of the thyroid cases and other cases where there has been a disturbance in the sex organs. What is to be done with many of these cases is a question yet to be solved. While a few of these patients have come to the office with infections in the breast, a heightened leukocyte count and a low afternoon fever, others have shown no such symptoms. The former group have been operated; the latter have been placed on the waiting list and their general health improved as much as possible, especially if they are young girls the removal of whose breast would be a distinct handicap to their future happiness.

Most of the other benign tumors of the breast have been removed because of disfigurement or lack of positive means of diagnosis.

Many authors advise the removal of all lumps from the breast. Many such lumps appear in young girls before marriage. Many of these are connective tissue overgrowths, the immediate removal of which is uncalled for because most of them respond readily to the treating of focal infections, good food, marriage and children. While it is true they may reappear, as old mastitis of nursing may reappear in later years, it is probably better to wait and treat them at this later period.

Cancer is not a local disease. Our recent studies have indicated that it depends not only upon a certain type of local degeneration, but also upon a drop in the general nutrition or health of the patient. When we have appreciated this fact and have looked upon our cancer patients as patients whose general health must be restored first, then many more cures will be the result. Cancer is not a disease to be treated by any one particular method. There is no such method. Each cancer must be removed completely or otherwise destroyed by the simplest method available. Each case is a problem by itself. It is a disease which must be treated by men skilled both in pathology and general clinical methods. Cancer deals with the most fundamental problems of life. It is an overgrowth of cells. It is not a true disease. It is a reaction which may take place in any area suffering degeneration when there is a drop in the general nutrition of the organism. Its treatment demands not only its removal, but the restoration of the patient to his former state of health.

Treatment of Diabetic Coma.—At the Peter Bent Brigham Hospital, nurses and house officers have received the following instructions for the management of diabetic coma:

1. As soon as the patient arrives place him in a warm bed.
2. Give an enema and obtain a blood and urine sample.
3. Give 1000 c.c. of saline subpectorally at once.
4. Give 25 units of insulin at once.
5. Give insulin about every two hours thereafter until the urine becomes sugar-free, judging the dose by the amount of sugar present in catheter urine specimens. When the urine becomes sugar-free continue to examine it at ¾-hour intervals using enough insulin to prevent the return of glycosuria and acidosis.
6. Let the patient have about 4000 c.c. of fluid each 24 hours during the first few days in the form of subpectoral injections, rectal taps or fluids by mouth. The rectal tap should consist of 5 per cent glucose in saline or tap water. Do not use sodium bicarbonate.
7. As soon as the patient becomes cooperative, let him have small amounts of warm fluids to drink, and, by way of food, as much orange juice, ginger ale, or oatmeal gruel as he likes.
8. As soon as the patient's condition warrants it, allow him to eat a low calorie "soft" diet including milk, cream, butter, crackers, eggs, and cereals.
9. Comatose patients whose acidosis does not improve, as measured by the plasma bicarbonate, within eight hours after insulin is first given, should receive 25 gm. of sodium bicarbonate by mouth, rectum or vein during the course of a few hours. This dose should be repeated in twelve hours if acidosis persists.
10. Diabetic patients admitted to the medical wards with any complication of a possible surgical nature (carbuncle, gangrene, lymphangitis) should be seen by the Surgical Resident at once. A diabetic patient can be prepared for operation in a few hours by the proper use of insulin.
11. Hypoglycemic reactions are to be treated with the oral or rectal administration of 10-20 gm. of sugar. Intravenous injections of sugar are rarely needed.—*Journal of the Medical Society of New Jersey.*